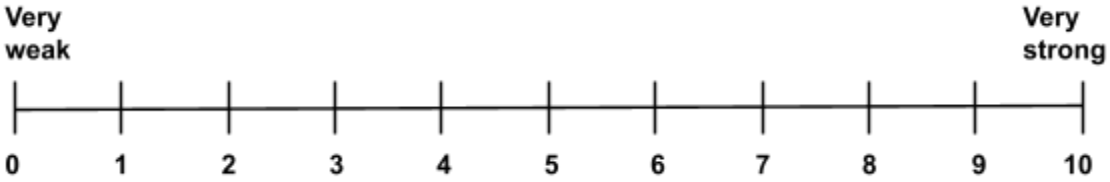
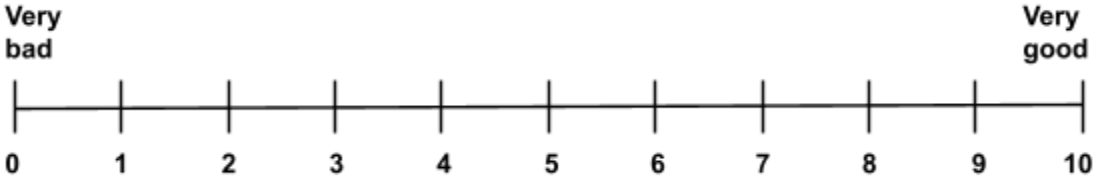
Wellness Questionnaire

Patient Name:	Date:

1. On a scale of 0-10, how would you rate your core strength?



2. On a scale of 0-10, how would you rate your quality of sleep?



3. How many times per night do you wake up to use the bathroom?

0-1 2-4 4+

4. How many times per week do you exercise?

0 1-3 4-6 6+

5. During the last month, have you accidentally leaked urine? (e.g. when laughing, jumping, sneezing)

Yes No